

## **SLIDE # 1 Integrating Religious and Spiritual Practices with Therapeutic Leisure within the Recovery Process of Persons with Mental Disorders**

**SLIDE # 2** “*He who has a why to live can bear almost any how*”. — Friedrich Nietzsche      “*Man is not destroyed by suffering; he is destroyed by suffering without meaning*”. — Viktor Frankl

This presentation proposes a model for combining therapeutic leisure experiences with religious and spiritual practices for supporting the recovery process of those suffering from a mental disorder.

## **SLIDE # 3 : Brief Overview of Mental Disorders**

According to the World Health Organization (2012), more than 450 million people worldwide suffer from a mental disorder, with 75% of persons remaining untreated in developing countries. Mental disorders such as intellectual disability, autism, schizophrenia, bipolar disorders, anxiety disorders, depressive disorders and neurocognitive disorders are mainly characterized by cognitive impairment, mood disorders and chaotic behaviours associated with distress and impaired functioning. As Miscale (2014) pointed out, mental disorders have an evolutive effect and the role of the *Diagnostic Statistical Manual of Mental Disorders* might only cause an escalation of ‘new’ diagnosis and a proliferation of the pathologization of everyday life. As Gilman (2014) affirmed, **and I quote**, “the realities of what constitutes madness in any given society or community or historical moments are constantly shifting: symptoms change and their meanings seem always in flux” **End of quotation**. Too often, as Deegan (2007) confirmed, patients who are living in a

psychiatric facility have to demonstrate normative behaviour to a greater degree than individuals outside of the facility. Society's moniker of 'mentally crazy' invokes a dehumanizing effect. Patients who feel vulnerable internalize their diagnosis telling themselves: 'I am a schizophrenic or I am a manic-depressive' becoming unable to see themselves beyond the boundaries of their diagnosis. However, Kehoe (2009) pointed out that persons with mental disorders are still a complete human being and able to experience spiritual health. They are nevertheless stigmatized as 'crazy persons' and may unintentionally receive a cognitive death sentence, *the death before death* as Deegan (2007) pointed out; or the entrance in *the kingdom of shadows*, as Robi & Leclerc (1990) affirmed together. The psychiatric services can act as a social punishment system where the patients are condemned with a diagnosis for actions that are outside of their control. At the beginning of their injury, patients with severe schizophrenia for instance are caught in a catatonic state where they are not in touch with their own reality. Szasz (1974) declared in an ironic manner that, **and I quote**, "[i]f you talk to God, you are praying; if God talks to you, you have schizophrenia" (p. 113). **End of quotation.** He concluded that no person or group should have the moral authority, **and I quote**, "to 'correct' a human being; only God does" **End of quotation.** Psychiatric patients are full human beings, and from a Christian worldview are sons and daughters of God who need the profound love, care and protection available to

all children of God. The problem of discrimination lies mostly in terms of the environmental factors and does not emanate from the persons with the disability. Thus by creating and continuing to strengthen the negative social stigma and refusing to see persons with disabilities as human beings first, our society contributes unwittingly to the creation of vulnerable populations. Importantly, the vulnerability results from a long period of prejudice, denigration or slander, exclusion, exaggeration or misdiagnosis which stigmatizes persons with physical or mental disabilities. These intensify social stereotypes. Barber (2012) explained that a patient is stigmatized with few alternatives from the beginning of his/her mental disorder by a prognosis which carries a life sentence that burdens his/her conscience. The therapeutic words used are relevant when a person receives a mental disorder diagnosis. She suggested a new medical approach: **SLIDE # 4:**

Traditionally, a psychiatrist told a patient with a new diagnosis of schizophrenia, 'You will have to take medication for the rest of your life,' comparing the illness to diabetes. Using our knowledge of current research findings, we could give a more hopeful prognosis: 'You will have to take medication for several years and may need to be hospitalized at times. But over time, you have an excellent chance of recovery and of needing less or even no treatment (2012, p. 278).

Religious and spiritual practices provide a significant pathway to instill hope and aid the journey to recovery.

### **SLIDE # 5 Religious and Spiritual Dimensions of Therapy**

There is hesitation in tackling the subjects of religion and spirituality in the medical community. As Kehoe mentioned (1999), these aspects of human experience are

viewed through the lens of a psychiatric symptom, something relatively pathological. This reluctance to engage religious and spiritual practices in the recovery process is due to their inherent amorphous nature and lack of specific empirical studies in the mental health field. Concerted attempts have been made to conceptualize and operationalize religion and spirituality.

Religion and spirituality have various meanings, but are often considered simultaneous or synonymous in contemporary societies. As Hill & Pargament (2008) stated, religion is sometimes defined as a construct that is structured, outward, institutional, authoritarian, doctrinal, inhibiting, substantive and negative, as opposed to spirituality, which is personal, inward, emotional, relational, subjective and positive. This distinction implies a restricted perspective that, as Koenig (2004) made clear, **and I quote**, “[s]pirituality is more individualistic and self-determined, whereas religion typically involves connection with shared beliefs and rituals” (p. 1194). **End of quotation.** He has also add that during the painful experience of mental disorders, religion and spirituality may play a role, **and I quote**,: “Whether it is as a new method of coping or a lifelong belief, religion becomes increasingly important as patients face the Goliath of illness”. **End of quotation.** (p. 1194). As Lacombe (2009) emphasized, surveys indicate that 95% of mentally ill patients do believe in God, whereas 79% believe that spirituality is important for a healthy life. This data demonstrates the importance of religion and

spirituality to persons with mental disorders. Koenig (2004) suggested that physicians can no longer ignore religion and spirituality factors. They should adopt whole-person medicine which, **and I quote**, “is the best kind of care both for those who receive it and those who give it” (p. 1199), **End of quotation**. The boundaries between physicians and patients are important and need to be constructed over time. As such, there is a unique point of equilibrium to each patient that requires an alliance of trust between patients and their physicians and also professional therapists as Ricoeur (2001a, 2001b) underlined by saying, **and I quote**, “the patient’s association with the course of its treatment, this alliance of trust that makes the physician and the patient allies in their common fight against the disease and the suffering” (p. 232). Furthermore, as Levin pointed out (1996), the therapeutic effects of prayer and meditation produce spiritual healing through gratitude, grace, relaxation, hope, inner peace, tranquility, forgiveness and love which facilitate behaviours that promote a general calming effect (Levin, 1996). In general, the literature points to the relevance of religion and spirituality in therapy and their potential positive effect on the recovery process of those suffering from mental disorders.

## **SLIDE # 6 Evidence-Based Recovery Practices Utilizing Religion and Spiritual Practices**

Hölzel (2011) and Lazar (2005) suggested that mindfulness and meditation practices enhance the network density in the brain structure resulting in improved

mental functioning. By preserving cortical thickness, meditation might attenuate depression, dementia and the aging process as Xiong and Doraiswamy (2009) wrote. More recently, Miller et al. (2014) have demonstrated that religious and spiritual practices have positive effects in the brain which may result in a reduction of depression symptoms. A thicker brain cortex is linked with high levels of religious and spiritual engagement and creates resiliency in depressive persons who have a high familial risk of deep depression. This expansion of cortical reserve possibly may counter some of the cortical thinning present in persons with a genetic predisposition to depression. Hence, as Miller et al. (2014) declare, **and I quote**, “[t]he importance of religion or spirituality appears to confer a neuro-anatomical resilience in those who are otherwise predisposed to developing depressive illness” (p. 134). **End of quotation.** A multitude of psychotherapy approaches in North America include innovative group settings or personal encounters with professional therapists, who discuss religious resources, sharing values concerns, spiritual struggles, hope and forgiveness; and encourage prayers and meditations practices as an adaptive strategy to manage and cope with the stress associated with mental disorders. For example, the Spirituality Matters Group (SMG) inside hospital settings reported by Revheim and Greenberg (2007), **and I quote**, “allow individuals with persistent psychiatric disabilities to explore positive emotion-focused coping” (p. 310). **End of quotation.** Bellamy et al.

(2007) revealed that patients with mental disorders who attended consumer-centered services found that religiousness and spirituality contributed to psychological well-being with decreased psychiatric symptoms, and overall improvement in management of one's daily life. For Corrigan and al. (2013), religiousness and spirituality had beneficial outcomes to social inclusion, hope, personal empowerment and recovery. For Tepper, Rogers, Coleman and Malony (2001), these also prevent possible future hospitalizations by the practices of religious coping methods, such as prayer, attending religious services, worshipping God, meditation, reading scriptures and meeting with a spiritual leader. These findings are theorized to be caused by understanding that, as Kehoe (2009) emphasised, **and I quote**, “[r]eligion is meant to bind us to the external Creator and not to bind us internally with knots of fear, anxiety, and prejudice. Spirituality, with its root in spirit or breath, refers to the source of life” (p. 51). **End of quotation.**

### **SLIDE # 7 Finding meaning through work engagement**

The work environment plays an important role in mental health. However, the unemployment rate for persons suffering with mental disorders is over 80%. Unemployment reduces life expectancy, increases homelessness and hinders the pursuit of life, liberty and happiness. Psychiatric patients are faced with social stereotypes that significantly limit stable employment conditions. Currently, in the province of Quebec, a practical rehabilitation program called “Peer Helping” exists

for persons who have or have had mental disorders. Participants share their painful experience and recovery stories in order to give hope; serve as leaders; and provide inspiration support and information to patients who come from similar situations. In addition, there is a need for a recovery mentor at work in order to prevent problems associated with prejudice and social stereotypes.

### **SLIDE # 8 Conceptual Models of Recovery**

A theory that is useful to consider is the transactional theory by Lazarus & Folkman (1984). It explains how people may adapt to stressful situations by thwarting personal goals and limiting their overall global health. This theory demonstrates how coping strategies may produce positive and/or negative consequences in physical condition, social functioning and psychological status. This theoretical framework has revealed fruitful connections between the various factors in stress appraisal and management saying that, **and I quote, SLIDE # 9:**

feelings can shape thought and action; (2) actions can shape thought and feeling; (3) the environment shapes thought, feeling, and action; and thoughts shape feeling and action. (pp. 345, 348). **End of quotation.**

**SLIDE # 10** This transaction model expresses that when the stressor is perceived negatively these two processes actually inhibit problem solving and positive changes within the relationship of the person to their environment.

Jacobson and Greenley (2001) advanced a recovery-oriented model that includes both internal and external conditions. The internal conditions include hope, healing



and empowerment. The external conditions are comprised of the circumstances, human right, a positive culture of healing and recovery-oriented services.

Provencher (2007) pointed out that the person engaging in the construction of new dimensions of the self is capable of projecting a redefined meaning of the self into the future and therefore reinforces a sense of agency (Provencher, 2007). This growing sense of inner peace promotes a more inclusive rehabilitation. From this perspective, a disabled person becomes resilient when he/she presents and maintains improvement in psychiatric symptoms. This growth also optimizes his/her potential within a global health context such as the psychological well-being. This improved resiliency creates a new self-efficacy for future challenges and even the potential to reorganize past painful experiences into meaningful growth. This *pattern* of resiliency is one of many which characterize the transformation experiences of fully 'being in recovery'. Thus Provencher (2002, 2007) established a conceptual multi-dimension model of recovery by specifying the characteristics of four specific dimensions of recovery.

**SLIDE # 11** In the *redefinition and expansion of the self*, the person forgets his/her role as patient and applies his/her energy to new roles which allow for re-building an improved self-esteem. In the *relationship with the temporal space*, the person searches for meaning in his/her potential future life, through the endeavor of hope and spirituality. The *empowerment* process is mainly characterized by the

transformation from feelings of helplessness into an increased sense of agency in their environment and building-up proactive goals through intrapersonal, interactional and behavioural components within organizational and communal levels. The *relationships with others* are characterized by the establishment of authentic and reciprocal connections to family, friends, peers or professional therapists. As Provencher (2007) affirmed ‘Being in recovery’ incorporates parental, occupational, educational, leisure and other roles (Provencher, 2007). Leisure experiences have significant therapeutic outcomes for persons ‘being in recovery’ and their search for a better quality and meaning of life.

#### **SLIDE # 12 Pathways to Recovery and Spiritual Well-being through Leisure**

Leisure practices can be employed as Cassidy (2005) notified as, **and I quote**, “a focus for interventions to improve health and to prevent illness”. **End of quotation.**

In some way, as Lord and Hutchison (2007) declares, the mental disorder persons build a new life story by learning as they go. They have the opportunities to grow and change resulting in positive social inclusion. Leisure presents a license to experience a spiritual transformation of the inner life which is exhibited in our actions towards the Lordship of Jesus Christ and all our fellow human beings (Spykman, 1994). As Heintzman (2010) wrote, there is a necessity to emphasize the transcendence. Religious and spiritual practices have a specific recovery effect because it offers time for, as Beglund affirmed, **and I quote**, “finding

transcendence through the ordinary”. **End of quotation.** (Berglund, personal communication, June 10, 2015). Leisure may provide many pathways, as Karlis, Grafanaki and Abbas (2002) reported, to connect with oneself and others, to create and find meaning, and to discover God. Schmidt and Little (2007) described how leisure affords persons the opportunity to experience spirituality. Kelly (1987) proclaimed leisure is not a frivolous experience, but is associated with notions of both creativity and freedom. Ultimately, leisure experiences are fundamental practices of openness, independence and restoration of the human soul, all important dimensions for the journey to recovery.

#### **JACK: SLIDE # 13 and 14**

Iwasaki, Coyle and Shank (2010,) pointed out that, **and I quote**, “[l]eisure is a key context for active living and an important pathway toward recovery, health promotion and life-quality enhancement. Leisure represents broad aspects of human functioning including emotional, spiritual, social, cultural and physical elements” (p. 485). **End of quotation.**

Haworth and Lewis (2005) affirmed that the therapeutic function of leisure is a factor in well-being. As such, Bouwer (2013) declares courageously that, **and I quote**, “spirituality often gives a sense of well-being, improves quality of life, and provides social support” **End of quotation** (Bouwer, 2013, p. 280). According to Iwasaki et al. (2014, 2015), for adults with a mental disorders, meaning-making

through leisure provides positive emotions, well-being, identities, self-esteem, spirituality, social and cultural links, harmony, human strengths, resilience, learning and finally human development throughout the life span. It may even diminish the perception of boredom, and replace it with enjoyment, interest and excitement for the leisure experience.

For its part, casual leisure is this kind of leisure which is helpful in the recovery process for persons with mental disorders. Hutchinson and Kleiber (2005) report that casual leisure supported persons to cope with stressful situations and negative life events and offered positive self-protection, self-restoration and personal growth. In cases of stressful circumstances, unexpected traumatic events and chronic stress, casual leisure activities such as watching a movie or a television program, strolling, napping, praying, meditating, dialoguing, having conversation and playing board games are definitely stress reducers. In addition, listening to music has demonstrated positive effects for individuals. Thus, for Magee and Bowen (2008), music therapy goes beyond just functionally rehabilitating the brain as it can also create a positive mood, which reduces the negative effects of the brain injury. The practice of music therapy is a substantial asset for recovery.

In front of the difficulty of aging in the social world, the come back to the roots of leisure is more than possible. As Genoe and Whyte professed, **and I quote:** “Emphasis on engagement in quality leisure as an end in itself may provide

opportunities for creating new narratives of aging that frame later life as a time of possibility, meaning, and growth, rather as one of decline and incompetence”. **End of quotation.** (Genoe & Whyte, pp. 239, 241). Genoe (2010) has also presented evidence that the social world of leisure is important for resisting the stereotypes of dementia and preventing the stigma associated with the aging process. In this regard, leisure is an efficient tool to resist personal adversity and reduce obstacles in society that affect persons with mental disorders and open personal space for meaning. Dupuis et al. surveyed persons who practiced inclusive leisure and reported statements like, **and I quote: SLIDE # 15** “*to be me, be with, make a difference, seek freedom, find balance, grow and develop and have fun*” **End of quotation** (p. 245). These dementia patients struggled with their changing mental capacities. They also found ways to tackle life with this disease as Genoe encouraged us, **and I quote, SLIDE # 15:** “*by reconciling life as it is, battling through by being proactive, living through relationships, being optimistic, and prolonging engagement in meaningful activity to live their lives with hope*”. **End of quotation.** (Genoe & Dupuis, 2014, p. 33). This behavior change involves the projection and the immersion of the self into the social world in spite of risks. As Warner, Doble and Hutchinson pointed out, despite the difficulties faced in recovery through rehabilitation for successful aging, there is a need to be able to look toward the future with the anticipation of, **and I quote,** “*having something*

*meaningful to do and the opportunity to connect with others” End of quotation.*

(Warner, Doble, & Hutchinson, 2012, p. 255). The therapeutic function of leisure is an alternative way to fulfill human needs, actualize our sense of self and produce authentic meaningful partnerships, while journeying with mental disorders.

It should be emphasized that, as Bouwer (2013) presented, **and I quote:**

“[a]lthough sporadic, there seems to be consistent conceptual and empirical evidence that leisure is capable of renewing the human soul and providing a free space for exploring the self and human connection” **End of quotation** (Bouwer,

2013, p. 289). In fact, as Pieper (1952) pointed out, **SLIDE #16:** leisure is “‘a mental and spiritual attitude’, ‘an attitude of the mind’, and ‘a condition of the soul’. ‘leisure implies [...] an attitude of non-activity, of inward calm, of silence [...] ‘it means not being busy’, but letting things happen” (Pieper, 1952, pp. 40-41).

Thus, leisure is highly connected to the religious and spiritual practices. Leisure may also be seen as a psychological experience and a pathway to attain peace with ourselves and our environment. As Livengood (2009) declares, it is primarily a “spiritual state of mind” (Livengood, 2009, p. 412) where, as Dubos (1974) affirmed, an organic joy is possible in the course of ordinary life (Dubos, 1974).

Neville (2004) confirmed that, **and I quote**, “[l]eisure is a way of knowing God, knowing what he has made me to be, and knowing, in the silence which follows

when competitiveness is shut out, the God who has given free time as a gracious gift” (p. 147). **End of quotation.**

### **SLIDE # 17 Recommendations and Future Directions**

Here some recommendations and future directions for the global health improvement of persons with mental disorders:

### **SLIDE # 18**

- Promote empirical research about the beneficial clinical effects of religion, spirituality and leisure experiences as a natural place for treatment to the vulnerable persons with mental disorders as a disability;
- Sensitize and train professional therapists within psychiatric services to be ‘spiritually-informed’ by creating a learning culture in order to enhance the quality of life of their patients;
- Develop consumer-centered services and spirituality matters groups (SMG) within the hospital settings for persons with severe schizophrenia and for those with mental disorders who wish to attend such psychotherapy groups;

### **SLIDE # 19**

- Organize therapeutic leisure experiences focused on conflict resolution and stress coping activities;
- Continue applying the “peer helping” program within the social work services and education certifications.

**(SLIDE # 20)**

***THANK YOU !***